STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
MONROE CORRECTIONAL COMPLEX
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PERSONAL & CONFIDENTIAL DELIVERY

April 18, 2019

Julia Barnett
Facility Medical Director
Monroe Correctional Complex

Ms. Barnett:

Notification of Disciplinary Action

This is official notification that I am discharging you from your Facility Medical Director position (FMD) position #C688, with the Department of Corrections (DOC), at Monroe Correctional Complex (MCC), effective immediately. Additionally, you will be paid fifteen calendar days in lieu of notice. This disciplinary action is being taken in accordance with Washington Administrative Code (WAC) 357-40 of the Civil Service Rules.

Misconduct

This disciplinary action is for the following misconduct:

During the period of January 16, 2018 through September 10, 2018, you failed to exercise sound clinical judgement; provide adequate medical care to patients; advocate for patients; make timely and necessary arrangements for adequate medical care to be provided to patients outside of MCC; ensure that providers whom you clinically supervised were providing timely, adequate medical care, evaluations or assessments; ensure that sufficient documentation and charting was occurring so that the patient's condition could be adequately monitored; and communicate significant changes in a patient's condition to other critical medical providers. Specifically:

1. Patient L.J. (See investigation attachment 12, 13 and 14)

   a. During the period June 8, 2018 through August 25, 2018 you failed to exercise sound clinical judgement and failed to provide adequate medical care, or ensure that others were providing adequate medical care, when this patient's pulmonary condition was deteriorating, yet you maintained the patient in the MCC Inpatient Unit (IPU) under the status of Housing only (requiring the patient to be seen as needed), and then to Observation in the MCC IPU (requiring the patient to be seen monthly) instead of assigning him to Skilled Care in the MCC IPU (requiring the patient to be seen daily). You also failed to ensure that you or the providers you clinically supervised were providing timely, adequate medical care, evaluations and assessments.

b. During the period July 24, 2018 through August 25, 2018, you failed to exercise sound clinical judgement, failed to advocate for this patient and failed to make necessary arrangements for adequate medical care to be provided outside MCC when you failed to timely send this patient to an outside medical provider for further medical evaluation and treatment. The patient's oxygen/pulmonary function was declining, with oxygen levels ranging from 92% down to 54%, and the patient at times refusing the nebulizer and nasal cannula (NC). The patient was afraid to use a facemask, frequently had a dry cough, fever, chills, labored or course breathing and complaints of being unable to breathe. The patient's oxygen level diminished to 44% on August 25, 2018, he had signs of blue lips and blue fingernail beds, and the patient stated, "I don't want to die here."

2. Patient C.P. (See investigation attachments 8 and 9)

During the period August 31, 2018 through September 4, 2018, you failed to exercise sound clinical judgement, failed to provide adequate medical care, and failed to advocate for this patient to make necessary arrangements for timely and adequate medical care to be provided outside of MCC. On August 31, 2018, you directed this patient to be housed in the MCC Close Observation Area (COA), even though it was suspected that he had inserted a six inch woodless pencil up his urethra. RN Jana Robison was concerned that the pencil was in the patient's bladder. The patient had bloody urine, lower abdominal cramping, and a history of inserting foreign objects, yet you continued to house the patient in the COA until September 4, 2018, when an x-ray was performed, which confirmed the foreign object. You then agreed to transfer him to an outside medical facility for further evaluation and treatment, where his bladder was determined to be perforated and the pencil was surgically removed.

3. Patient J.K. (See investigation attachments 15, 16 and 17)

a. During the period June 18, 2018 through August 22, 2018, you failed to provide or ensure that providers whom you clinically supervised were providing timely, adequate medical care, evaluations and assessments regarding this patient, and to ensure that adequate documentation and charting was occurring so that the patient's condition could be adequately monitored. This patient had an open abdominal wound, complained of increased abdominal pain, and experienced changes in his symptoms to include difficulty breathing, pain in his left flank and ribs, shaky hands, appetite changes, vomiting and diarrhea.

b. On August 6, 2018, you failed to exercise sound clinical judgement and failed to advocate for this patient to make necessary arrangements

for timely, adequate medical care to be provided outside MCC when you denied a request to send this patient to an outside medical provider, for further medical evaluation and treatment. Nursing staff expressed concerns that the patient's wound was tunneling, that they were unable to suction back any fluid when the wound was irrigated, and that the fluid may be going into his peritoneal cavity. The patient's condition continued to decline through August 22, 2018, when you finally agreed to send him to the hospital.

4. Patient B.A. (See investigation attachments 10 and 11)

   During the period of September 9, 2018 through September 12, 2018, you failed to exercise sound clinical judgement, failed to provide or ensure that providers whom you clinically supervised were providing timely, adequate medical care, evaluations and assessments and failed to adequately communicate significant changes in this patient's condition to other critical medical providers. This patient had had complications following two prior wisdom teeth extractions, and returned from an area hospital on September 9, 2018. You maintained the patient in the MCC IPU until September 10, 2018, under Observation instead of Skilled Care, despite his complications. You failed to ensure that you, or the providers whom you clinically supervised, evaluated the patient prior to releasing him from the MCC IPU later on September 10, 2018, or to consult with one of the facility dentists. You discharged the patient from the MCC IPU on September 10, 2018 with patient symptoms of swelling on/in the right side of his throat/jaw, unable to eat, and pain described as 10/10. You issued only pain medication, Magic Mouthwash and ice packs. The patient returned to the MCC IPU on September 11, 2018, with a fever of 102.3, increased facial swelling, unable to swallow, breathing with his mouth open, inner mouth swelling to the back of his epiglottis, and feeling like he was drowning. On September 12, 2018, the patient was then sent out again for outside medical intervention, where he was maintained in an Intensive Care Unit.

5. Patient C.S. (See investigation attachments 18, 19 and 20)

   a. During the period January 16, 2018 through August 22, 2018, you failed to exercise sound clinical judgement when you agreed to perform bilateral plantar wart excisions on the bottom of both feet of this patient. This patient also had Diabetes, which complicated the patient's medical condition and healing.

   b. During the period March 30, 2018 through August 3, 2018, you failed to provide or ensure that providers whom you clinically supervised were providing timely, adequate and standard medical care, evaluations and assessments when this patient received "bi-weekly" Cryotherapy treatments to both feet, over an extended period of time which would not allow the skin time to heal prior to the next treatment.

6. Patient P.H.(See investigation attachments 20 and 21)

   a. During the period February 6, 2018 through March 17, 2018, you failed to exercise sound clinical judgement, failed to advocate for this patient to make necessary arrangements for timely, adequate medical care to be provided outside MCC, and failed to adequately communicate significant changes in the patient's condition to other critical medical providers. This patient had been discharged from Evergreen Hospital on February 5, 2018. Upon his discharge, Evergreen recommended that he be seen by Endocrinology, but you failed to ensure that this medical consult occurred. On or about February 14, 2018, you failed to appropriately document and/or to ensure that providers whom you clinically supervised were appropriately documenting the patient's medical record when the diagnosis of Diabetes Insipidus (DI) was added to his medical conditions without sufficient records of why the diagnosis was added.

   b. During the period January 23, 2018 through March 17, 2018, you failed to provide or ensure that providers whom you clinically supervised were providing, timely, adequate medical care, evaluations and assessments and failed to ensure that adequate documentation was occurring so that the patient's condition could be adequately monitored. There is an inadequate number of encounters recorded in the Offender Management Network Information system (OMNI) between January 23, 2018 through March 17, 2018 and an inadequate number of examinations and assessments recorded in the patient's medical record between the period of February 26, 2018 through March 17, 2018.

   c. During the period February 6, 2018 through March 17, 2018, you failed to exercise sound clinical judgement and failed to provide or ensure that others were providing adequate medical care when this patient was placed on Desmopressin (DDAVP), which can cause Hyponatremia, and allowed the patient to continue on DDAVP until March 17, 2018.

   d. During the period February 6, 2018 through March 17, 2018, you failed to exercise sound clinical judgement and failed to advocate for this patient to make necessary arrangements for timely, adequate medical care to be provided outside MCC, when this patient was allowed to remain in the MCC IPU instead of being sent to an outside medical provider for further evaluation and treatment for his deteriorating conditions. The patient was not sent out for outside medical intervention until March 17, 2018 when he was unable to eat, drink or take medication, was lethargic and barely arouseable, and had a sodium level of 115. He died the same day with cause of death cited on his Death Certificate as Electrolyte Disorder. Also noted on the Death Certificate were other conditions contributing to death, to

include: Diabetes Mellitus, recent Viral Meningitis, and probable Arteriosclerotic Cardiovascular Disease.

Investigation

Investigator 3, Cassandra Chalmers, completed a fair and thorough investigation into this matter with the assistance of Dr. Patricia David and Dr. Sara Kariko. During the investigation the following information was provided:

1. Patient L.J. (See investigation attachments 12, 13 and 14)

   This patient was initially transferred from the Washington State Penitentiary, with oxygen (O2) saturation of 95-99% on June 8, 2018. On approximately July 28, 2018, his O2 levels began to drop to 89%. You were asked by Dr. David why there was no diagnostic workup given this patient's sudden oxygen level drop, or consultation with the Pulmonologist, who had evaluated him for lung transplantation, prior to his transfer to MCC. After reviewing the medical record, you said it appeared that the patient's change in pulmonary status occurred gradually over the course of approximately two months. You said that you had several conversations with the Physician Assistant (PA-C) about the need to consult a Pulmonologist for recommendations, and particularly before adding medications to the patient's regimen. You said the patient's June 2018 typed notes from the Pulmonologist were not in his DOC record, but you recalled reviewing and printing them. You also said that there was also at least one report to you that the Pulmonologist had been called, but had not returned the call. You further stated that it appeared the patient did not always wear his oxygen and sometimes the results were recorded on room air instead.

   Dr. Kariko asked whether the patient's status ever changed to Skilled Care when his condition began to deteriorate. After reviewing the medical chart, you said the Infirmary Face Sheet had both Observation and Housing checked on June 8, 2018, and there was no date documented as to when the patient was placed on Long Term Care. You did not mention any Skilled Care placement. You also added that you recalled having a great deal of discussion regarding the patient's desaturations. You said, initially, it would occur when he wasn't using his oxygen, and then when he began using his oxygen all the time, it would occur only at night. You said you were first notified (of further oxygen desaturation) on August 7, 2018, and your assessment at that time was that he was a mouth breather and he needed to use prongs in his mouth. However, you said that August 7, 2018, was also the beginning of the unhealthy air quality warnings for the Seattle, Washington area, which continued for the next two weeks. Around this time, you said you received an email that one of the night nurses complained to "admin," skipping you entirely, that this patient was desaturating and nothing was being done. You said this prompted you to raise the issue in the nurses meeting, that you expected to be informed if such an event happened again.

Dr. Kariko asked what your rationale was on August 19, 2018 for placing the patient under Observation instead of sending him to the Emergency Room (ER) when the patient's O2 saturation ranged from 56 to 70%. You said the nurse called you when the patient's O2 increased to 70% and you asked the nurse at that time to check the patient's O2 level again and call you back. However, you never received another call. You stated that you were not called again about this patient until 0645 hours on August 25, 2018, and you sent him out to an outside hospital at that time.

Dr. David asked you why the patient was not evaluated by a practitioner during the period August 20 through August 23, 2018, why there were no encounters noted in OMNI or notes entered in the patient's medical record by a practitioner. During this period, the patient was described by nurses as having "air hunger" and respiratory distress with an O2 saturation drop as low as 60%. You said there were fairly extensive daily discussions with nursing regarding his care.

2. Patient C.P. (See investigation attachments 8 and 9)

During your investigatory interview, Dr. Kariko asked you why, on August 31, 2018, this patient was transferred to the COA instead of the IPU or other options, when it was suspected that he had inserted a pencil into his urethra. You stated that the patient did not appear unstable medically, and that the COA had a nurse on duty at all times.

You were asked about a response you made that was noted by nursing on August 31, 2018, at 1230 hours. When the nurse asked you what the plan was for this patient, you responded, "We don't do anything as long as he can urinate" and "it is unlikely he pushed it all the way in." In response to this question, you stated, "X-ray was unavailable at the time of the injury, for reasons that aren't clear in the chart.", You further stated that the usual process for urethral insertions was not to send the patient to the ER unless there was actually a foreign body present that required surgical removal, or if the patient was unable to urinate. You said this patient's entire medical plan hinged on the x-ray results, and as long as he continued to void and remained hemodynamically stable, the x-ray was not an emergency.

Dr. David stated during her investigatory interview that the patient had blood in his urine, that the pencil was assumed to have been in his bladder, and he was not sent out to the ER until September 4, 2018. The patient was then hospitalized for a perforated bladder. When the investigator, Ms. Chalmers, asked if the pencil should have been removed and the patient then re-evaluated and put into the COA to be monitored, Dr. David said, "Right, yes."

3. Patient J.K. (See investigative attachments 15, 16 and 17)

You were asked by Dr. David during the investigatory interview why you denied the nursing requests to send this patient to the hospital on August 6, 2018. The nurses documented concerns that fluid was going into the patient's Peritoneal Cavity, that the surgical wound was not returning fluid when irrigated, and that there was tunneling around the wound. Dr. David also asked why the patient wasn't assessed by a practitioner given the nursing notes from August 6, 2018. You said that RN Susan Rhoads' medical note was timed at 1230 hours on August 6, 2018, and that at 1410 hours, there was an order to change the dressing, which would indicate that a provider assessed the wound and determined that an ER visit was not necessary. You stated that the following day, there was also lab work returned, indicating the patient's nutritional status was being assessed related to wound healing, and that the wound care flow sheet also indicated the wound had become significantly smaller during the period August 1 to 8, 2018.

Dr. Kariko asked why there was no exam of the abdomen specific to flank/rib pain/Dyspnea, when new symptoms were noted on August 11, 2018. You stated that August 11, 2018 was a Saturday, and the patient had been seen by PA-C Bo Stanbury on August 10, 2018. You stated that you were also at his bedside on Monday August 13, 2018, and determined that his pain was clearly thoracic rather than abdominal. When you were asked why there had been no abdominal exam since July 26, 2018, by a practitioner, and no encounters in OMNI during the period August 2, 2018 through August 22, 2018, you stated his pain appeared thoracic instead of abdominal, and from your recollection, he was being monitored very closely by the nurses and the providers, which you said was supported by the records. You further stated that the medical records show that PA-C Jennifer Ross wrote orders on August 14, 2018, that she saw the patient on August 15, 2018, and performed a procedure on August 17, 2018. On August 20, 2018, she wrote more orders, all of which you stated would have required an exam.

Dr. David stated during her investigatory interview that after the nurses requested that the patient be sent to the hospital, the patient continued to have pain not just in his abdomen, but in the left flank and rib area, and he was having difficulty breathing. She stated that nothing really happened other than giving pain medication, and when he died, he had Acute Pancreatitis and Duodenal Perforation. She said the wound had been open for several months and the nursing staff were pretty familiar when they changed the dressing what the wound looked like, and how it reacts when you irrigate it. If they were concerned, she would have sent him to the ER. Had he been sent, at the very least, he wouldn't have passed with such pain. His pain level went from 8/10 to 12/10 while in the IPU. She also stated that he should have been seen daily, as he had been having abdominal pain for months and, in addition, there were the concerns by the nurses as well as new symptoms.

Dr. Kariko stated during her investigatory interview that it appeared that the patient was not seen by a provider until four days after the new symptoms occurred. She said a patient being treated with wound vac should be seen daily. The patient was also receiving daily medications for pain and, in that situation, needs to be evaluated frequently. If a nurse comes to a practitioner and says the patient is complaining of new symptoms, Dr. Kariko indicated that she would expect if she was the Medical Director, to either evaluate the patient herself, or the provider should have gone to see him and evaluate. Dr. Kariko stated that they should have taken a complete history, asked the patient questions such as when did the pain start, and what makes it better or worse, in order to determine the diagnosis. An abdominal exam should have been done, head to toe, and the wound area checked for worsening infection or bleeding. With concerns from the nursing staff, he should have been seen daily and an evaluation done with a note written to support the decisions.

4. Patient B.A. (See investigation attachments 10 and 11)

Dr. David asked you why there was no practitioner evaluation on September 10 or 11, 2018, when this patient began complaining September 10, 2018 of being unable to eat food. On September 11, 2018, he also complained of increased swelling, having to breathe with his mouth open, unable to swallow fluid, and the nursing notes stated there was swelling in his mouth extending back to his epiglottis. You stated that you had previously sent him to the ER on September 8, 2018 due to complications from two wisdom teeth extractions that initially occurred on September 6, 2018. When he returned from the outside medical facility on September 9, 2018, he received his medication in the IPU, and on Monday, September 10, 2018, you felt he was appropriate for discharge. You stated he was not happy about that and the next day he came to sick call several times, complaining of difficulties swallowing and swelling. He was provided supportive therapy, on the presumption he was taking his Clindamycin as instructed. You added that he admitted later that he had not been taking his medication. On September 11, 2018 at 0700 hours, you said the normal provider for the Minimum Security Unit (MSU) was on approved medical leave, so the nurse called you to describe her assessment. She informed you there was swelling but no difficulty breathing. You said she informed you about his "subjective" complaint regarding his inability to swallow, and that she made no note that he was drooling. At 0735 hours on September 11, 2018, PA Robin Smith wrote admitting orders and at 0800 hours there were nursing vitals performed. You said from your recollection, PA Smith reported her exam findings to you and over the course of the day, he appeared to be responding. You said that he was administered IV antibiotics and the following day he went to the hospital.

Dr. David asked if you recalled whether Dr. Laura Hale, one of the Dentists at MCC, tried to reach you or visit the patient. You said that you only recalled that Dr. Hale made a complaint to Health Care Manager 3,

Billy Heinsohn, that you didn't call her, and you didn't recall her ever trying to reach you. When asked what the dental process was for follow up of IPU patients, you said the nurse is supposed to look at the return paperwork, call the dentist and get orders from them. If there is no dentist on site, the patient stays in the IPU overnight. The PA would write any necessary orders and the patient would be discharged the next morning if all remains well. You then said, upon more reflection, you might have received a call from Dr. Hale, complaining about why the patient was sent to the ER without dental being notified, but the reason was because the incident occurred on the weekend.

5. Patient C.S. (See investigation attachments 18, 19 and 20)

Dr. David asked why you decided to offer excision for this patient's plantar warts, and whether other options were discussed. You stated it was PA Smith's treatment plan, which she discussed with the Care Review Committee on May 31, 2018, and it was approved. When asked whether you were aware of this patient's diabetic neuropathy and poorly controlled diabetes, you said you discovered a note you had written on March 27, 2018, detailing your explanation of the risk and benefits of multiple treatment options, but the patient insisted that he had tried most other options and the only thing that worked was excision. You also said he chose to do both feet at the same time despite your advice to do one foot at a time. When you were asked why Cryotherapy was performed in a twice-weekly regimen, you said the initial plan was weekly and on May 18, 2018, PA Smith changed it to twice weekly. You admitted that twice weekly was a nonstandard regimen, that the rationale in the medical records was unclear, and that you did not recall PA Smith consulting with you about this change.

6. Patient P.H. (See investigation attachments 20 and 21)

You were asked why this patient was changed from Skilled Care to Long Term Care on February 9, 2018, when he was orthostatic, getting Intravenous (IV) Normal Saline (NS) Boluses and frequent Basic Metabolic Panels (BMP), he was unable to transfer independently and required assistance. You said, regardless of his level of care, very close tabs were being kept on him, and the records showed that on February 15, 2018, he was changed back to Skilled Care. You also added that you believed during that period, his care decisions could be made based on a nursing assessment and that he was switched back to Skilled Care for close monitoring, during DDAVP therapy. When Dr. David asked why an Endocrine consultation had not been ordered as recommended upon the patient's discharge from the hospital February 5, 2018, you said that you recalled that a consult *had* been ordered, but the placeholder that is normally placed in the chart was not there. You also indicated that the hospitalist's test results were questionable, as they had diagnosed the patient with adrenal dysfunction and you did not agree with the diagnosis. You also said there was an issue of how to maintain continuity of care

since the patient was due to release very soon. On or about February 15, 2018, the diagnosis of diabetes insipidus (DI) was added to his medical conditions without sufficient records of why the diagnosis was added. When Dr. David asked who diagnosed this patient's DI that was added to the problem list on February 15, 2018, you said it was not clear who made the diagnosis, and it should have been on the problem list as a presumptive diagnosis. You said it *was* on your differential diagnosis when you saw him on January 22, 2018, and you recalled having extensive conversations with PA Ross, the IPU provider at the time, regarding what diagnostic testing could reasonably be performed at the IPU. When water deprivations studies were then performed, the results came back consistent with DI. You admitted it was not documented well.

When, you were asked why there were no encounters in OMNI from January 23, 2018 until the date of death on March 17, 2018, and no practitioner examinations from February 26, 2018 until March 17, 2018, you said it was because you had not set expectations that the PAs note all of their outpatient encounters in OMNI. To clarify, you added that OMNI was not considered part of the medical record at that time, it was a mechanism for data collection and an interface with custody. Outpatient visits required an entry in OMNI, to inform custody about medical visits and once made, the entry needed to be resolved. Inpatient visits did not have appointments in OMNI that needed to be resolved, so you asked the PAs to enter encounters if they had time, but you did not penalize them if they didn't. You also stated that, after reviewing the chart, you did not know why there were no practitioner examinations documented after February 26, 2018. You explained that there was a changeover of IPU providers at that time, and you specifically recalled providing both written and verbal instructions to the new provider, regarding documentation requirements. You also recalled that the patient was seen regularly by the provider, monitored closely, and discussed with you at length numerous times.

When you were asked who recommended the DDAVP that was prescribed, you said that after water deprivation tests, PA Smith and you discussed it, and determined that a trial of DDAVP was warranted. You said the patient was watched carefully and, as you recalled, he tolerated it well, his urine output and dizziness decreased, and he required fewer fluid boluses to maintain his blood pressure. You stated he was later switched from nasal spray to pill form, due to concerns about the patient's ability to pay for his medication after release and to restrict fluid intake. You said that you worked with the PA to carefully try to convert him to the pill form, prior to his release. When you were asked why the patient was allowed to continue on DDAVP when he was Hyponatremic, you said the goal was to avoid rapid swings in sodium levels, due to the risk of Osmotic Demyelination. After PA Smith consulted with you, it was agreed to decrease the dose rather than stop it.

Pre-Disciplinary Meeting

The pre-disciplinary letter and a disk containing the investigation report, which described these charges in detail, was provided to you, on March 26, 2019. I held a pre-disciplinary meeting with you on April 1, 2019. Also present at this meeting was Human Resource Consultant, Evie Green.
At this meeting, we discussed the investigation and the charges brought against you. During the meeting I asked you to present any information you wanted me to consider before I made a decision regarding the alleged misconduct and appropriate sanction. You read a written response at the pre-disciplinary meeting, which you later provided a copy of (Attachment A).

Findings and Standards

After careful review of the information provided to me through the investigation and the April 1, 2019, pre-disciplinary meeting, I find that the above allegations of misconduct are substantiated.

During your investigatory interview, you stated that the process for the MCC IPU was that, in the mornings at 9:00 a.m., there was discussion with the PAs and nurses about all of the patients. You said that attendance was open to any clinical staff who needed to obtain or contribute to patient information. If a nurse or PA felt that you needed to see a patient, you would do rounds with them if their concerns could not be answered without seeing the patient. In the afternoon, the PA would sign out either verbally, over the phone, or by email, giving you an update on the status of each patient before they left. You said that when an advanced practitioner was covering the IPU, you would visit and evaluate the patients admitted there at the request of the PA, or when the PA had doubt about the direction of care. You were also present on the unit on a daily basis for at least part of the day and your office was also just down the hall.

In regard to documentation and visit frequency, you stated that your expectations were that practitioners were expected to see and document Skilled Care patients daily, Long Term Care patients monthly, and Observation patients as needed. All non-Housing patients required a History and Physical within seventy-two hours, and Observation patients required a disposition to Skilled, Long Term Care, Housing or discharge within seventy-two hours. Practitioner documentation was expected to appropriately reflect the patient visit and status, usually in the form of a SOAP (Subjective, Ohjective, Assessment, Plan) note or an abbreviated version of same.

1. Patient L.J. (See investigation attachments 12, 13 and 14)

    a. I find that you failed to exercise sound clinical judgement and failed to provide adequate medical care, or ensure that others were providing adequate medical care, in regard to patient L.J., during the period June 8 through August 25, 2018, when the patient's condition deteriorated. He should have been placed under Skilled Care but, despite his deteriorating condition, he was maintained under the status of Long-Term Care per the Infirmary/Extended Observation Unit Face Sheet (DOC-13-050) which shows an admission date of June 8, 2018 with "Long-term care", "Housing Only", and "Observation" noted as the admission status. The level of care was changed to "long-term care"

however the notation does not indicate when or by who. It is also clear that the patient was not evaluated by a practitioner during the period August 20 through August 23, 2018. There were no encounters noted in OMNI or notes entered in the patient's medical record by a practitioner. Your response when asked about this was that there were fairly extensive daily discussions with nursing regarding his care. I find this to be inadequate. You stated in your investigatory interview as well as during the pre-disciplinary meeting, that you had daily discussions with PA-Cs and nurses, regarding patients in the IPU, and that you had many discussions regarding this patient, yet you contradict this by stating during the pre-disciplinary meeting that you were not made aware of this patient's episodes of poor oxygenation until much later than was appropriate. You also stated during the investigatory interview that you did not receive a call regarding this patient until August 25, 2018, when you then sent him to the hospital.

You were however made aware of the patient's deteriorating condition based on the practitioners and nursing notes dated August 7, 8, 9, 10, 13, 19 and 23, 2018. You also indicated during your investigatory interview that a nurse complained on August 7, 2018, that the patient was desaturating and that nothing was being done. Despite this complaint, the patient was not sent to the ER, nor was he sent to the ER on August 19, 2018, when his O2 saturation ranged from 56 to 70%. Instead, he was placed under Observation instead of Skilled Care. When a nurse called to inform you the same day that the patient's O2 level had increased to 70%, you asked her to check it again and call you back. However, you did not receive a return call, nor did you follow up with the nurse.

There were no further notes from practitioners or you, August 20 to 24, 2018, no evaluations by a practitioner, no encounters noted in OMNI or the patient's medical record during the period August 20 to 23, 2018, when the patient was described by nurses as having "air hunger," was anxious, and exhibiting respiratory distress, with an O2 saturation drop as low as 60%.

On August 24, 2018, at 1129 hours, the Infirmary/Extended Observation Unit Progress Record signed by Registered Nurse 2 (RN), John Sordetto states, the offender called stating, "I … can't … breathe" with O2 saturation of 54% and resting rate of 60%. It required two nebulizer treatments to raise the patient's O2 level up to 80%. RN Sordetto's notes further state, "Called provider. J. Ross came to see inmate … nursing requested that the patient be sent out 911 but requests to send the patient to the ER were refused." On August 24, 2018, at 1230 hours, you, along with PA-C Jennifer Ross, saw the patient and advised him to use his mask or the NC in his mouth, and avoid any activity other than lying in bed. PA-C Ross and you determined at that time the patient would remain on the current plan. At 2100 hours the same day, the nurse reported this patient was

in respiratory distress with an O2 level of 50 to 60% when not using his mask. Despite nursing concerns and information provided to you repeatedly, requests to send the patient to the ER were not approved and at no time was a Pulmonologist consulted about the patient's deteriorating O2 saturation, nor was there a diagnostic workup performed by you, or the practitioners under your clinical supervision. There was one medical note from PA-C Stanbury on August 7, 2018, that states, "Scheduled f/u with Pulmonologist" and you stated during your investigatory interview that, "There was at least one report to me that the Pulmonologist had been called, but had not returned the call." Yet there was no further follow up done by you or the providers that you supervised.

b. I find that during the period July 24, 2018 through August 25, 2018, you failed to exercise sound clinical judgement, failed to advocate for this patient and failed to make necessary arrangements for adequate medical care to be provided outside MCC. On August 25, 2018 the patient's O2 levels continued to decrease to the 50 to 60% level, and at 0645 hours the patient was noted as gasping for air with an O2 level of 44%, with labored breathing, shaking, and blue lips and fingernail beds. The patient stated, "I don't want to die here," at which time you finally gave the order for staff to call 911. You had clearly been informed of this patient's deteriorating condition since August 7, 2018, yet you failed to exercise sound clinical judgement and advocate for this patient to receive appropriate consultation with a Pulmonologist, or to send him out for consultation with a Pulmonologist, or other outside medical care in a timely manner.

Furthermore, you continued to rationalize your decisions during the pre-disciplinary meeting, stating that you did not believe that the patient would have been admitted to the hospital had you attempted to admit him prior to when you did, and you were remiss of the fact that the patient had not been seen by a Pulmonologist or any other specialist, since arriving at MCC in June 2018.

2. Patient C.P. (See investigation attachments 8 and 9)

I find that you failed to exercise sound clinical judgement, to advocate for and to make necessary arrangements for timely and adequate medical care to be provided outside of MCC, when you allowed this patient to remain in the COA for four days, instead of sending him to the ER. It was believed that he inserted a pencil up his urethra on August 31, 2018. Adeleide Horne, PA-C, documented in the medical record on August 31, 2018, at 0030 hours, that the patient inserted a pencil into his urethra, believed to be six inches long, and that the patient could feel it coming out slightly when he tried to void. PA-C Horne further noted that the patient had blood at voiding, and pain and cramping described as 10/10. A medical note from PA-C Horne at 0655 hours stated that the patient felt like he was retaining urine. PA-C Horne stated that she discussed the

case with you, and you instructed her to transfer him to the COA rather than the IPU. The patient continued to have blood in his urine during this time and was not sent out to a hospital until September 4, 2018, at 1900 hours, when he was finally transported to Providence Hospital in Everett, Washington. The patient had the pencil surgically removed and underwent bladder repair surgery, and returned to the MCC IPU on September 7, 2018. Although you stated during your pre-disciplinary meeting that a reasonable physician might choose differently, and that did not make your choice wrong, I find that you unnecessarily delayed critical treatment, which placed the patient at further risk. Furthermore, your poor clinical judgment put this patient in undue pain and discomfort, and resulted in this patient's prolonged recovery.

3. Patient J.K. (See investigative attachments 15, 16 and 17)

   a. I find that you failed to provide or ensure that providers whom you clinically supervised were providing timely, adequate medical care, evaluations and assessments. I also find that you failed to ensure adequate documentation and charting was occurring so the patient's condition could be adequately monitored. This patient had an open wound over an extended period of time. Although there were various orders requested by providers during August 2018, there were no examinations noted during the period August 2 to August 21, 2018. You stated during the investigatory interview that the medical records show that exams were performed on August 14, 15, 17, and 20, 2018. However, on the 14th PA-C Ross ordered an x-ray, on the 15th she ordered an IV, on the 17th she performed wound site treatment and on the 20th she ordered another CXR to compare to the prior. At no time was there a note or encounters done by the providers, regarding the completion of a thorough exam, despite the patient continuing to deteriorate.

   - The medical records indicate that during the period June 18 through July 13, 2018, a wound vac was applied, the wound was dressed and the wound vac was assessed at several visits. The patient began to complain of abdominal pain on July 14, 2018 and until July 18, 2018, he was given various pain medication, yet his complaints of abdominal pain continued. On July 18, 2018, he complained of nausea and on July 23, 2018, he complained that the pain at the wound site was causing difficulty for him to sleep. On July 25, 2018, MRSA was found in the wound and isolated. During the period July 26, 2018, until August 6, 2018, blood tests were ordered, dressing was changed, and he was continued on medications for symptoms of pain and nausea. On August 6, 2018, nurses voiced their concerns that when the surgical wound was irrigated, there was no return and the wound was tunneling. They were concerned that the fluid was going (or had been going) into the peritoneal cavity. They felt the patient should be sent to an outside hospital for evaluation, which you denied. He continued being treated with medication. During the period August 8 through 10, 2018, wound

vac dressing treatments were applied daily. On August 11, 2018, the patient began to complain of pain in the left flank/rib and that it hurt to breath and nurses stated there was barely any discharge from the wound vac. On August 12, 2018, his pain was described as 10/10 and his hands were noted as shaking. On August 13, 2018, the patient continued to complain of left flank pain and cramping, the nurse was unable to touch his left side due to pain, and you ordered a collagen wound dressing. On August 14, 2018, an x-ray was ordered by PA-C Ross. On August 15, 2018, PA-C Ross consulted with you. The notes indicated that the x-ray showed left lower lobe "most likely representing pneumonia" and an order was placed for a CXR, Intravenous (IV) Cefepime/Doxy (antibiotics) and Robaxin (for pain). No abdominal exam was documented. On August 16, 2018, you were informed that the patient was asking for pain meds, but no order was provided. PA-C Ross ordered nutritional packets at the request of Brent Carney, the nutritionist. During the period August 17 to 21, 2018, the patient's appetite decreased, he had liquid stools, abdominal pain, nausea and vomiting. PA-C Ross notified the nurses on August 20, 2018 to notify the provider if there was sudden abdominal pain, if the patient stopped producing stools or had nausea and vomiting, though many of these symptoms had already been ongoing. On Tuesday, August 21, 2018, the patient's pain elevated to 12/10, radiating from the center of his chest to his spine, and he had shortness of breath with a tender abdomen and hypoactive bowel sounds, yet there was no practitioner exam. The patient was finally sent out to a hospital on August 22, 2018, stating he was dehydrated, and was described to be cold and clammy with respirations of 30-34.

It is clear to me that this patient should have been sent to an outside hospital based on his deteriorating condition that was repeatedly noted by the nurses August 6, 11 and 12, 2018, yet you refused until August 22, 2018 to make timely arrangements for outside medical care and treatment to occur.

b. I find that you also failed to use sound clinical judgement when, despite concerns from nursing on August 6, 2018, related to changes in the irrigation and appearance of his wound, you maintained this patient in the IPU and refused to send him to an outside hospital. Even during the period August 7 through 22, 2018, You continued to fail to advocate for this patient in the following weeks, despite the patient's deteriorating condition, his continued struggles with pain, new pain symptoms, difficulty breathing and sleeping, and shaky hands. You also failed to arrange for timely adequate medical care to be provided outside of MCC. Per a Primary Encounter Report dated August 20, 2018, the patient's medical conditions were Renal Cell Cancer, Malignant Neoplasm Liver, Neoplasm Not Otherwise Specified (NOS), Anemia NEC, Constipation, Edema and Abdominal Pain Generalized. When you finally agreed to send the patient to an outside hospital on August

22, 2018, he died August 27, 2018 due to pancreatitis, sepsis and a perforated duodenum.

4. Patient B.A. (See investigative attachments 10 and 11)

I find that during the period September 9 through September 12, 2018, you failed to exercise sound clinical judgement and to ensure that you or providers whom you clinically supervised were providing timely, adequate medical care, evaluations and assessments when you discharged this patient from the IPU on September 10, 2018 at 1122 hours, without sufficient monitoring or an examination by yourself or a practitioner. You also failed to exercise sound clinical judgement when you maintained this patient at the IPU, despite his complaints and multiple visits to sick call, due to a worsening of his condition until 0700 hours on September 11, 2018. This patient had oral surgery at an outside medical provider on September 6, 2018. He returned to the IPU on September 7, 2019, was sent to the ER due to complications on September 8, 2018, and returned to the IPU on September 9, 2018 at 1930 hours.

On September 10, 2018, at 1030 hours, progress notes from IPU written by RN Mary Avera indicated that the patient had slight swelling of his right jaw area, with level three difficulty eating and drinking. Despite his recent complications and hospitalization, you ordered Clindamycin, Prednisone, Ibuprofen and Senna (a laxative), and discharged the patient from the IPU back to MSU, at 1122 hours, less than twenty-four hours after he arrived, and without a physical evaluation from a practitioner. I find that you failed to adequately communicate significant changes in the patient's condition to other critical medical providers, specifically the dentist.

While at MSU on September 10, 2018 at 2010 hours, the patient went to sick call. Licensed Practical Nurse, Theresa Ledbetter noted that the patient was unable to swallow, and had swelling on the side of his neck, ear and jaw pain, and swelling inside his mouth. You ordered Magic Mouthwash, pain medicine and instructions for him to attend sick call in the morning. At 2320 hours on September 10, 2018, the patient went to sick call again. RN Paul Martin noted that the patient had swelling, was unable to open his mouth over 10 mm, described pain as 10/10 and was unable to eat. You kept the patient at MSU and ordered additional supportive therapy of an ice pack and medication.

The patient went to sick call again on September 11, 2018 at 0000 hours with complaints and was told again he would need to go to sick call in the morning. At 0700 hours, the patient returned to sick call and RN Susan Williamson noted swelling on the right side of the patient's face from cheek to eye, breathing with his mouth open, unable to drink fluids, unable to swallow, and a statement by the patient that it felt like he was drowning. He was hot to the touch and there was swelling in his mouth

on the right side, upper and lower jaw and cheek. The swelling appeared to extend back to his epiglottis and he was unable/unwilling to extend his tongue beyond his teeth stating it hurt. You then ordered that he be transferred to the IPU. The Admission Orders signed by PA-C Robin Smith ordered pain medication, IV antibiotics and a soft diet, and he was placed under the status of Observation. She also ordered blood cultures and requested dental consultation however, there is no evidence that you or any of the providers attempted to contact a dentist to consult on this case. On September 11, 2018 you ordered the discontinuance of prednisone and added an order of Cefepime. During the period 1300 hours to 2300 hours, the patient continued to have issues with pain, swallowing and swelling, and his temperature increased to 102.3.

On September 12, 2018 at 0800, RN Avera noted that the patient was having trouble breathing. He was evaluated by PA-C Smith and finally sent to the ER where he was admitted to the Intensive Care Unit at Evergreen Hospital in Kirkland, WA. He did not return to the MCC IPU until September 16, 2018.

It also concerning that during your investigatory interview, you admitted that the patient went to sick call at MSU several times after being discharged from the IPU during the period September 10 through 11, 2018, yet you described his complaints about not being able to swallow as "subjective," remiss of the fact he had not been evaluated by a practitioner prior to his discharge from the IPU or after. The patient's medical records also show little attempt to contact a dental provider and no follow up was noted. He should have been placed under Skilled Care for monitoring when he returned from the hospital on September 9, 2018. Instead, he was placed under Observation and discharged to MSU, despite returning from the hospital due to complications. It is apparent to me that this patient endured unnecessary discomfort and a difficult and lengthy recovery, due to poor clinical judgement by you and lack of adequate and appropriate practitioner involvement.

5. Patient C.S. (See investigation attachments 18, 19 and 20)

   a. I find that you failed to exercise sound clinical judgement when you performed bilateral plantar wart excisions on the bottom of both feet of this patient on March 30, 2018. Regardless of whether the patient preferred to do both feet at the same time, it was your decision whether or not to perform the procedure, in consideration of the patient's medical conditions of diabetic neuropathy and poorly controlled diabetes. You also failed to exercise sound clinical judgement when you failed to send this patient to an outside medical provider for further evaluation and assessment or to a Podiatrist until August 23, 2018. Your efforts to treat his condition were not working, and his ability to ambulate independently was deteriorating.

b. I find that during the period March 30 through August 3, 2018, you failed to provide or ensure that providers whom you supervised were providing timely adequate and standard medical care, evaluations and assessments when this patient received non-standard, bi-weekly (twice weekly) Cryotherapy treatments to both feet over an extended period of time. It is understandable that the words bi-weekly may have been misunderstood to mean twice weekly instead of every other week. However, the non-standard treatment continued for an unacceptable amount of time during the period April 25, 2018 through August 3, 2018, until the patient was finally sent to a Podiatrist on August 23, 2018. Additionally, you provided no direct follow up with the patient after performing the surgery March 30, 2018, or adequate oversight during the period above. He continued to have complications, which included the need for special shoes April 25, 2018, a wheelchair June 1, 2018, complaints of leg spasms June 20, 2018, having to ambulate with a cane, bi-lateral electrical leg pain June 23, 2018, and joint pain July 9, 2018. Regardless of continuous complaints of pain and discomfort, this patient was not sent out to see a Podiatrist until August 23, 2018.

6. Patient P.H. (See investigation attachments 20 and 21)

a. I find that you failed to exercise sound clinical judgement and to advocate for this patient to make necessary arrangement for timely, adequate medical care to be provided outside MCC, when the patient was maintained in the IPU during the period February 5 through March 17, 2018. The patient was having ongoing and increased complaints of dizziness, headache, double vision, inability to transfer or change clothes independently, decreased vision in his right eye, and chest pain. I also find that you failed to adequately communicate significant changes in the patient's condition to other critical medical providers. You failed to ensure that a consult occur with an Endocrinologist per the prior hospitalist's recommendation. It is of additional concern that you gave multiple reasons during your investigatory interview why a consultation with Endocrinology did not occur. You said that you were sure it had been ordered but the placeholder wasn't in the chart. You also indicated the hospitalist's test results were questionable, and that you did not agree with them. In regard to failing to appropriately document, and ensure that providers whom you clinically supervised were appropriately documenting, the patient's medical record when the diagnosis of DI was added to this patient's medical conditions, you admitted that it was not clear who made the diagnosis of DI on or about February 15, 2018. You recalled having extensive conversations with the PA regarding diagnostic testing, and that when water deprivation studies were performed, the results came back consistent with DI. There was clearly a failure to appropriately document and to ensure that providers whom you clinically supervised were appropriately documenting the patient's medical record.

b. In regard to failing to provide or ensure that providers whom you clinically supervise were providing timely adequate medical care, evaluations and assessments during the period January 23 through March 17, 2018, you stated that it was not your expectation for PA-Cs to enter Inpatient Encounters in OMNI as it was not part of the medical record. In response as to why there were inadequate examinations and assessments recorded in the patient's medical record between the period February 26 to March 17, 2018, you said you did not know why there were no practitioner examinations documented during this period. You could only state that there was a changeover of IPU providers during this time, and you specifically recalled providing both written and verbal instructions regarding documentation requirements. It was your responsibility to ensure that timely adequate medical care, evaluations and assessments occurred, yet the medical records reflect that that did not occur.

c. You failed to exercise sound clinical judgement and failed to provide or ensure that others were providing adequate medical care when it was determined to place this patient on DDAVP, which can cause Hyponatremia (a condition that occurs when the concentration of sodium, an electrolyte in the blood, is abnormally low). You said that you and the PA determined that a trial of DDAVP was warranted. You also stated that the patient was being watched carefully. However, the DDAVP treatment began February 15, 2018, and continued through March 16, 2018, with no documented practitioner examinations after February 26, 2018. The patient was in the IPU and should have been seen frequently, which required if not oversight by you, a personal review of the case. You should have been aware the patient had severely low sodium and that he either should not have not have been getting DDAVP or he should have been sent to the hospital. There are no records that you ever evaluated the patient personally, despite the seriousness of his condition and ongoing complications.

d. You failed to exercise sound clinical judgement and failed to advocate for this patient to make necessary arrangements for timely, adequate medical care to be provided outside MCC during the period February 6 through March 17, 2018. You allowed this patient to remain in the MCC IPU, despite his deteriorating condition, until March 17, 2018. At that point, he was unable to eat, drink or take medication, was lethargic, barely arousable, and had a sodium level of 115. He died the same day. The cause of death was Electrolyte Disorder. You stated during the pre-disciplinary meeting that you felt this patient died of Osmotic Demyelination Syndrome, resulting from an inappropriate increase in his DDAVP, which was ordered without consulting you and administered before you could intervene. You have an obligation to ensure appropriate oversight of the PAs under your supervision..

I find that you failed to provide adequate oversight to the providers you supervised or to provide sufficient direct patient care in order to ensure that

recommendations for strategies and optimal coordination of multidisciplinary health care needs for seriously ill patients was adequate, appropriate and timely. Despite having daily discussions with the providers under your supervision and concerns expressed by others on multiple occasions, you failed to advocate for these patients and delayed emergency medical care, which was essential to life and caused significant deteriorations in patients' medical conditions.

You failed to ensure that specialty medical consults occurred, and failed to document why the consults were not executed. You also failed to ensure evaluation and assessment medical documentation was adequate and that significant changes in a patients' condition were communicated to other critical medical providers. In relation to consults, the DOC Health Plan (Attachment B) states that DOC is not obligated to execute recommendations. However, these recommendations are subject to the same criteria as any other DOC provided care and when primary care practitioners do not execute consultant recommendations, they are expected to explain their reasons to the patient and document the reasons in the health record. In the case of patient L.J., you stated you informed the PA of the need to consult with the Pulmonologist many times, but that the Pulmonologist did not return the call. However, the referral occurred prior to June 8, 2018 and no follow up or consultation occurred prior to the offender being sent to the ER August 25, 2018. In the case of patient P.H., who was referred to Endocrinology by an outside hospital on or about February 5, 2018, you recalled that the consult had been ordered but the placeholder wasn't in the chart. You also added that the hospitalist's test results were questionable and you did not agree with them. Again, no follow up or documentation was completed to ensure the consult occurred or to document the reason it was not executed during the period February 5, 2018 to March 17, 2018. Other critical medical documentation was also insufficient as there were often lapses in documentation to support that adequate practitioner medical care, evaluations and assessments had occurred. When asked about these issues, you often said the patient was being monitored closely, and that you had extensive daily discussions with the PA's about the patient. This is insufficient and does not support the critical decisions made for the patients ultimately under your responsibility.

Patients who were seriously ill were often placed under Observation or Long-Term Care, which resulted in insufficient monitoring, instead of Skilled care, which would have required that they be seen daily. This left patients under the care and monitoring of nurses for long periods with inadequate practitioner involvement. When nurses voiced concerns and requested that patients be sent out to a hospital, their requests were often denied for too long. Thorough evaluations and assessments by practitioners were also non-existent or insufficient as shown by the patients' records. When treating these seriously ill patients, your lack of sound clinical judgement often delayed medical intervention that could and should have been provided to reduce or prevent the significant deterioration of patient symptoms. These delays may have made future care more dangerous, complicated and less likely to succeed.

You should have been aware that your behavior was in violation of:

- The Washington DOC Health Plan (Attachment B);
- DOC Policy #600.000 Health Service Management (Attachment C);
- DOC Policy #610.600 Infirmary/Special Needs Unit Care (Attachment D);
- The DOC Policy and General Information training you received on March 7, 2017 (Attachment E);
- Your Performance and Development Plan (PDP) Expectations for Supervisors and Managers (PDP) (Attachment F); and
- Your Position Description (PD) (Attachment G). (Your PDP states that your Position Description was reviewed with you.)

The DOC Health Plan (Attachment B) states in part:

F. Emergency Care

Medically necessary emergency assessment, treatment and related services will be available at all times…An offender may be transferred to a community clinic or emergency room for care, if the level of service required cannot be adequately provided in the facility's health care unit.

> If medically necessary, an offender may be transported by ambulance, including air ambulance, to expedite transfer to the most appropriate care setting.

IV. Definitions:

Medical Necessity [WAC 137-91-010]: Medically necessary care meets one or more of the following criteria for a given patient at a given time:

- It is essential to life or preservation of limb
- Reduces Intractable pain
- Prevents significant deterioration of ADL's
- Is of proven value to significantly reduce the risk of one of the three outcomes above
- Immediate intervention is not medically necessary, but delay of care would make future care more dangerous, complicated, or significantly less likely to succeed

XIII. Special Circumstances or Exceptions

C. Role of Consultants and their Recommendations

During the course of health care, patients are sometimes referred to consultants including specialists, ER providers and hospital providers. Such referrals often generate recommendations including instructions and orders. DOC is not obligated to execute these recommendations, which are subject to the same criteria as any other DOC provided care.

> ...When primary care practitioners do not execute consultant recommendations, they are expected to explain their reasons to the patient and document the reasons in the health record.

You violated the DOC Health Plan by failing to ensure medically necessary care was being provided consistent with the criteria above to these patients, by you, or the advance care practitioners you supervised.

DOC Policy #600.000 Health Service Management (Attachment C) states in part:

> II. Health Services Employee/Contract Staff Requirements
>
> D. Licensed providers will report through their chain of command to the Health Authority. The FMD will oversee clinical care in collaboration with the Chief Medical Officer and Clinical Directors.
>
> 1. All providers who provide clinical care to offenders will participate in formal clinical oversight according to the facility and Health Services clinical oversight structure.
>
> F. FMDs will ensure that the clinical care delivered in their facilities is appropriate, and will:
>
> 1. Have final clinical judgment at the facility level, unless superseded by the Chief Medical Officer.
> 2. Ensure that clinical care provided by the facility practitioners meets standards established by the Chief Medical Officer and is in accordance with the Offender Health Plan.
> 3. Collaborate with the Health Authority in administrative functions and operations that support appropriate clinical care.
> 4. Collaborate with facility clinical discipline leaders to ensure quality and appropriateness of care.

You violated Policy 600.000 Health Services Management by failing to provide adequate and appropriate clinical oversight of the advanced care practitioners you supervised. You also failed to ensure the clinical care provided by the advanced care practitioners met standards established by the CMO and in accordance with the Offender Health Plan.

DOC Policy #610.600 Infirmary/Special Needs Unit Care (Attachment D) states in part:

> Directive:
>
> 1. General Requirements

A. An infirmary is a specific area of a healthcare facility, separate from other housing areas, where offenders are housed and provided health services.

4. Health services provided while in the infirmary will be documented in the inpatient section of the patient's health record.

B. A Special Needs Unit is an area of a facility designated to house offenders who require Skilled Nursing Care, Extended/Assisted Living Care, or Sheltered Care, and who meet certain classification requirements.

1. Offenders assigned to the Special Needs Unit are considered outpatients.

C. An Extended Observation Unit (EOU) is intended for short stay medical observation of up to, but no to exceed, 96 hours.

1. EOU's will be operated per the Extended Observation Unit Protocol and all records associated with a patient's stay will be filed in the inpatient section of the patient's health record.

IV. Infirmary Levels of Care

A. Levels of care are applicable to medical, dental, and mental health patients and will be determined by the admitting practitioner at the time of admission to the infirmary.

B. The levels of care are defined as follows:

1. The Skilled Care level is for patients who require continuous services (eg., focused nursing/complex wound care, intravenous antibiotic treatment) and may include detoxification services when necessary.

b. The initial visit by a practitioner will be documented on DOC 13-013 Infirmary/Extended Observation Unit Progress Record and will include diagnosis, history of current problem, physical examination, assessment, and treatment plan.

1) All subsequent documentation, dictation, and progress notes will be maintained in the infirmary section of the patient's health record.

c. A practitioner will make and document patient care rounds at least once every business day.

2. The Infirmary Observation Admission level is for patients who are only in the infirmary for a planned medical trip, 24 hour urine collection, pre-postoperative care including dental procedures, or as determined by the practitioner.

3. The Long-Term Care level is for patients who require assistance with one or more activities of daily living and can no longer be managed in general population or housed in a Special Needs Unit.

e. A practitioner will make and document patient care rounds at least monthly.

VI. Transfer to Another Health Care Facility

A. Patients requiring a higher level of care may be transferred to another Department facility or a community health care facility....

You violated Policy 610.600 Infirmary/Special Needs Unit Care by failing to ensure that patients admitted to the IPU were done so under appropriate admission statuses for their conditions or changes to those conditions.

The DOC Policy and General Information training you received on March 7, 2017, (Attachment E) explains that you are expected to understand and abide by Department Policies and Expectations. It further states that it is your responsibility to review policies on IDOC for the most up to date information throughout your employment.

Your PDP Expectations for Supervisors and Managers (Attachment F), signed by you on July 11, 2017, states:

Key Results Expected

2. Review and decide the care level of practitioner consults in a timely manner
3. Adherence to Offender Health Plan, formulary guidelines, DOC protocols and accepted medical evidence in providing and authorizing care
4. Demonstrate clinical skills and judgement suitable for supervising other practitioners in a primary care outpatient or infirmary setting
10. Adhere to medical record documentation standards per DOC policy

You violated your PDP Expectations by failing to ensure medical care was following the OHP, established protocols and guidelines. Further, you did not demonstrate appropriate judgement or clinical skills for those you supervise, and failed in ensuring proper documentation in the patient record so continuity of care could be maintained.

AND

The CORE Competencies for All Employees as written in your PDP Expectations which states in part:

Judgment and Problem Solving:
Makes timely decisions based on the best information at hand. Can describe the factors that were considered in making a decision and their relative importance. Identifies and considers alternatives before making a decision. Seeks advice from others. Considers the impact of decisions on co-workers, clientele, and other program areas. Solves problems effectively.

You violated the CORE Competency for Judgment and Problem Solving by failing to make timely decisions based on the best information at hand. Had you reviewed the health records of these patients, you would have noticed the absence of appropriate and adequate clinical medical evaluations, assessments and documentation.

Your Position Description states:

This position analyzes, directs, and coordinates medical care provided to the patients at Monroe Correctional Complex....The Facility Medical Director has oversight of all medical decisions and care at the facility and can countermand another clinician at the facility level.

Primary Responsibilities (Duties and Tasks):

- Provide administrative and clinical direction and oversight to all medical providers at the facility
- Review clinical compliance with the Department policies, Health Services Standard Operations and Procedure Manual including Health Services Offender Health Plan and DOC-DOH Health Environmental and Safety Standards
- Plan the delivery of health care services at the MCC facilities. Take after hours call as necessary.
- Design, approve, and monitor clinical delivery processes at the facility levels.
- Ensure implementation of and adherence to DOC Offender Health Plan, Policies, and Protocols
- Provides direct patient care to meet facility requirements; care provided may be consultative in assisting other primary providers or as needed may be direct primary care as required to meet the facility obligations.

Accountability

- Has direct responsibility for the quality of medical care and shared responsibility for the overall quality of clinical services at the facility/facilities directed.

Decision Making and Policy Impact

- This position is the final authority at the facility level on questions of appropriateness and quality of medical care, including systematic issues of care delivery and medical management of individual cases. This position is also responsible for recommending strategies for optimal coordination of multidisciplinary health care at the facility level...

You failed to meet the expectations in your position description when you failed to provide appropriate or adequate clinical oversight of the advanced care practitioners, ensure care being delivered to patients met DOC standards of care, and to adequately monitor clinical delivery processes.

Determination of Sanction

In determining the appropriate level of discipline, I reviewed your previous work history, length of service, training provided, and your history of employment with DOC.

- You were hired as a Physician 3 with MCC on March 6, 2017 and promoted to Facility Medical Director on May 1, 2017.

- Your training records (Attachment G) reflect that you completed DOC Policy and General Information training.

Your actions and inactions have proved your inability to perform your duties as a FMD. You had an obligation to ensure appropriate oversight of the PA-Cs under your supervision and I believe that your lack of direct involvement and monitoring violated DOC policies regarding patient care and the health services that are provided to patients under DOC's custody.

As the FMD, you have the final authority and direct responsibility for the quality of medical care, and appropriateness of medical care, provided to patients. Despite having daily discussions with the providers under your supervision, and hearing concerns expressed by others on multiple occasions, you failed to advocate for these patients and delayed emergency medical care that was essential to life and that which caused significant deteriorations in patients' medical conditions. Your actions and inactions potentially created risk to the patients' health and safety and risk to the Department. I cannot tolerate risk to patient health and safety, or risk to the Department. I no longer trust your clinical judgement and ability to be responsible for the health and welfare of the patients at MCC.

Accordingly, I have determined that discharge is the appropriate level of discipline. Any lesser sanction would not express the seriousness with which I view your misconduct, deter others, or maintain the mission, integrity and reputation of the agency.

Appeal Rights Under the provisions of the Washington Administrative Code (WAC) 357-52-010 and 357-52-015, you may appeal this action by filing an appeal to the Washington State Personnel Resources Board (PRB), Appeals Program, 128 10th Avenue SW, Olympia, Washington 98504-0911. Your appeal must be in writing, and received by the PRB within thirty (30) calendar days after the effective date of the action specified in the first paragraph of this letter.

Eric Hernandez, Administrator – Command B
Health Services Division

EH:eg

Attachments:
Julia Barnett's - Pre-Disciplinary Response (A)
Washington DOC Health Plan (B)
DOC Policy 600.000, Health Services Management (C)
DOC Policy 610.600, Infirmary/Special Needs Unit Care (D)
Julia Barnett – Training Transcript (E)
Julia Barnett's - Performance and Development Plan Expectations (F)
Julia Barnett's – Position Description Form (G)

cc: Personnel File (including pre-disciplinary letter and investigation)
Payroll File (first paragraph only)